EXHIBIT "D"

I, PATIENTS NAME, give authorization to Western Medical to contact my doctor(s) to request a prescription and medical records on my behalf for the [list braces(s)]. Also, I confirm that I have a medical need, which my physician is aware of, for these products [this product].

I understand that Western Medical will disclose only the minimum Personal Health Information necessary as needed for the services requested. I also understand that Western Medical will send me a copy of their Privacy Policy, HIPAA policy, Client Bill of Rights and Responsibilities, and a complete copy of the Medicare DME Supplier Standards.

PATIENTS NAME, please state your name and the date confirming you understand and agree with the information I just provided to you.

12/12/13, 1:36:59 PM MST